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7
8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 2011-22

13 **EVELYN MANIACUP BUAN**

A C C U S A T I O N

14 **4203 Arboretum Drive**
15 **Pasadena, Texas 77505**

16 **Registered Nurse License No. 619144**

17 Respondent.

18 Complainant alleges:

19 **PARTIES**

20 1. Louise R. Bailey, M.E.D., RN ("Complainant") brings this Accusation solely in her
21 official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"),
22 Department of Consumer Affairs.

23 **Registered Nurse License**

24 2. On or about June 2, 2003, the Board issued Registered Nurse License Number
25 619144 to Evelyn Maniacup Buan ("Respondent"). The registered nurse license was in full force
26 and effect at all times relevant to the charges brought herein and will expire on December 31,
27 2010, unless renewed.

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1 8. On or about May 31, 2006, pursuant to Findings of Fact, and Conclusions of Law, in
2 the disciplinary action entitled *In the Matter of Registered Nurse License No. 599103 Issued to:*
3 *Evelyn Maniacup Buan*, the Texas Board disciplined Respondent's nursing license.

4 9. The Texas Board ordered Respondent to receive the sanction of remedial education
5 including not practicing nursing outside the state of Texas without the written permission of the
6 Texas Board, taking and completing a course in Texas jurisprudence, nursing documentation, and
7 patient safety, within one year. The discipline ordered by the Texas Board was ordered as a result
8 of the following;

9 a. On or about July 5, 2005, while employed at Kindred Hospital Houston Northwest,
10 in Pasadena, Texas, Respondent failed to correctly administer 'moderate/conscious
11 sedation medications', as ordered by the physician, to Patient Medical Record Number
12 14274. Respondent failed to verify by calculation the appropriate dosage of
13 *Succinylcholine chloride*, and consequently failed to question the excessive dose ordered
14 by the physician prior to administering the medication to the patient. Respondent states
15 she administered the medication prematurely before the physician arrived and before the
16 patient was intubated, which resulted in the patient experiencing respiratory arrest. In
17 addition, Respondent failed to request assistance from the Charge Nurse in the emergent
18 intubation procedure that followed. Respondent's conduct may have contributed to the
19 patient suffering respiratory arrest.

20 b. On or about July 5, 2005, while employed at Kindred Hospital Houston Northwest, in
21 Pasadena, Texas, Respondent failed to accurately and completely report and document in
22 Patient Medical Record Number 14274, the change in patient status, nursing assessment
23 and evaluation, and the necessary interventions elicited for stabilization of the patient.
24 Respondent's conduct resulted in an inaccurate medical record and was likely to injure the
25 patient in that stabilization of the patient. Respondent's conduct resulted in an inaccurate
26 medical record and was likely to injure the patient in that subsequent care givers would
27 not have complete information on which to base their care decisions.

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